a) By using the rate established for the previous owner for the previous rate year; or

b) By establishing a rate based on the previous owner's cost report, if the previous owner submits a cost report and allows the audit of that cost report, and if the change of ownership occurred after the report year end but prior to the beginning of the rate year.

c. A facility may choose to have a property rate established, during the remainder of the rate year and the subsequent rate year, based on interest and principle payments on the allowable portion of debt to be expended during the rate years. The property rate must go into effect on the first of the month following notification by the department. The difference between a property rate established based on the facility's election and a property rate established based on paragraph b, multiplied by actual census for the period, must be determined. The property rate paid in each of the twelve years, beginning with the first rate year following the use of a property rate established using this paragraph, may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

6. For a facility terminating its participation in the medical assistance program, whether voluntarily or involuntarily, the department may authorize the facility to receive continued payment until medical assistance residents can be relocated to facilities participating in the medical assistance program.

7. At such time as twelve months of property costs are reflected in the report year, the difference between a projected property rate established using subsection 2 or 3 and the property rate that would otherwise be established based on historical costs must be determined. The property rate paid in each of the twelve years, beginning with the first rate year following the use of a property rate established using subsection 2 or 3 may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

Section 29 - One Time Adjustments

1. Adjustments to Meet Certification Standards and 1987 OBRA Requirements

   a. The department will provide for an increase in the established rate for additional costs that are incurred to meet certification standards. The survey conducted by the Department of Health and Consolidated Laboratories must clearly identify that the facility must take steps to correct deficiencies dealing with resident care. The plan of correction must identify the salary and other costs that will be increased to correct the deficiencies cited in the survey process.

      (1) The facility must submit a written request to the Medical Services Division within thirty days of submitting the plan of correction to the Department of Health and Consolidated Laboratories. The request must contain the following information:

         (a) A statement that costs or staff numbers have not been reduced for the report year immediately preceding the Department of Health and Consolidated Laboratories certification survey.

         (b) The number of new staff or additional staff hours and the associated costs that will be required to meet the certification standards.

         (c) A detailed list and implementation of any other costs necessary to meet survey standards.

      (2) The department will review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate will be adjusted to an amount not to exceed the limit rate.

   b. The department will accept requests for a rate adjustment for additional costs incurred to meet OBRA 87 requirements. Adjustments for OBRA 1987 costs will be processed as facility specific beginning with the legal effective date of October 1, 1990, as follows:

      (1) Facilities submit costs in a format selected by a facility that best portrays these costs to the department that are anticipated by them to fall within OBRA requirements.

(2) Department staff screen facility costs submitted per item 1 against OBRA legal requirements which specify services involved and compare the result against the prior cost history to establish whether any duplication exists between what has been included in the request and what may already be in the rate from a prior cost report. Health Department survey staff is called upon to assist in such analysis as needed.

(3) Costs related to the OBRA 1987 requirements not reflected in the current rate are processed in accordance with provisions found elsewhere in the approved payment plan. A revised rate is issued no earlier than October 1, 1990, or the date on which the expenses for complying with OBRA 1987 began reflecting the total OBRA cost component and what portion of the rate is attributable to OBRA. (See Appendix B for explanation of rate calculation)

c. Any additional funds provided by adjustments to meet certification standards or 1987 OBRA requirements must be used in accordance with the facility's written request to the department and are subject to audit. If the department determines that the funds were not utilized for the intended purpose, an adjustment will be made in accordance with Section 26 - Rate Adjustments.

2. Adjustments for Unforeseeable Expenses.

a. The department may provide for an increase in the established rate for additional costs that are incurred to meet major unforeseeable expenses. Such expenses must be resident related and must be beyond the control of those responsible for the management of the facility.

b. The facility must submit a written request containing the following information to the Medical Services Division within sixty days after first incurring the unforeseeable expense:

(1) An explanation as to why the facility believes the expense was unforeseeable.

(2) An explanation as to why the facility believes the expense was beyond the managerial control of the owner and/or administrator of the facility.

(3) A detailed breakdown of the unforeseeable expenses by expense line item.

TRANSMITTAL NO. 92-003
Date Approved 10/14/92
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Supersedes Transmittal 91-02

c. The department will base its decision on whether the request clearly demonstrates that the economic or other factors that caused the expense were unexpected and arose because of conditions that could not have been anticipated by management based on their background and knowledge of nursing care industry and business trends.

d. The department will review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate will be adjusted upward not to exceed the limit rate.

e. Any additional funds provided must be used to meet the unforeseeable expenses outlined in the facility's request to the department and are subject to audit. If the department determines that the funds were not utilized for the intended purpose, an adjustment will be made in accordance with Section 26 - Rate Adjustments.

3. Adjustment to Historical Operating Costs

a. A facility may receive a one time adjustment to historical operating costs when the facility has been found to be significantly below care related minimum standards and when it has been determined that the facility cannot meet the minimum standards through reallocation of costs and efficiency incentives.

b. The following conditions must be met before a facility can receive the adjustment:

(1) The facility must document that based on productive nursing hours and standardized resident days, the facility cannot provide a minimum of 1.2 nursing hours per standardized resident day.

(2) The facility must document that all available resources, including efficiency incentives, if used to increase nursing hours, are not sufficient to meet the minimum standards.

(3) The facility must submit a written plan describing how the facility will meet the minimum standard if the adjustment is received. The plan must include the number and type of staff to be added to the current staff and the projected cost for salary and fringe benefits for the additional staff.

c. The adjustment will be calculated based on the costs necessary to increase nursing hours to the minimum standards less any incentives included when calculating the established rate. The net increase will be divided by standardized resident days and the amount calculated will be added to the actual rate. This rate will then be subject to any rate limitations that may apply.

d. If the facility fails to implement the plan to increase nursing hours to 1.2 hours per standardized resident day, the amount included as the adjustment will be adjusted in accordance with the methodologies set forth in Section 26 - Rate Adjustments.

e. If the actual cost of implementing the plan exceeds the amount included as the adjustment, no retroactive settlement will be made.

4. Adjustments for Disaster Recovery Costs when Evacuation of Residents Occurs

a. A facility may incur certain cost when recovering from a disaster such as a flood, tornado, or fire. If evacuation of residents was necessary because of the disaster, operating costs incurred during the recovery time cannot be allocated to resident care because there are no residents receiving services. Actual recovery costs, net of insurance recoveries, may be considered as deferred charges and allocated over a number of periods that benefit from the costs. State per Barb Fischer 7/31/97

b. When a facility has evacuated residents and capitalizes recovery costs as a deferred charge, the recovery costs must be recognized as allowable costs amortized over sixty consecutive months beginning with the sixth month after the first resident is readmitted to the facility.

c. Recovery costs shall be identified as start-up costs and included as pass through costs for report purposes. Recovery costs may not be subject to any limitations.

d. If a facility evacuates residents, the ninety percent occupancy limitation may not be applied during the recovery period or for the first six months following the month the facility readmits the first resident.

e. Insurance recoveries relating to the disaster recovery period must be reported as a reduction of recovery costs. Insurance recoveries received after the first month of the sixty month amortization period must be included as a reduction of deferred charges not yet amortized, except that the reduction for insurance recoveries may occur only at the beginning of a rate year.

Section 30 - Notification of Rates

1. The department will notify each facility of the desk audit rate on or before November 22 of the year preceding the rate year.

2. The facility must provide to all private-pay residents a thirty day written notification of any increase in the rates for each classification. No increase in rates is effective unless the facility has notified the private-pay residents. A facility may make a rate change without giving a thirty day written notice when the purpose of the rate change is to reflect a necessary change in the case-mix classification of a resident.

3. If the department fails to notify the facility of the desk rate by November 22 of the year preceding the rate year, the time required for given written notice as provided for in subsection 2 will be decreased by the number of days by which the department was late in setting the rate.

Section 31 - Reconsiderations and Appeals

1. Reconsiderations

   a. Any requests for reconsideration of the final rate must be filed with the department's Medical Services Division for administrative consideration within thirty days of the date of the rate notification.

   b. A request for reconsideration must include:

      (1) A statement of each disputed item and the reason or basis for the dispute;

      (2) The dollar amount of each adjustment that is disputed; and

      (3) The authority in statute or rule upon which the facility is relying for each disputed item.

   c. The department may request additional documentation or information relating to a disputed item. If additional documentation is not provided within fourteen days of the department's request, the department shall make its determination based on the information and documentation available as of the fourteenth day following the date the department requested additional documentation.

   d. The department's Medical Services Division will make a determination regarding the reconsideration within forty-five days of receiving the reconsideration filing and any requested documentation.

2. Appeals

   a. A provider dissatisfied with the final rate established may appeal, upon completion of the reconsideration process as provided for in Subsection 1. An appeal may be perfected by mailing or delivering, on or before five p.m. on the thirty-first day after the date of mailing of the determination of the Medical Services Division made with respect to a request for reconsideration, the information described in subdivision 1) through 5) of this subsection to the department, at such address as the department may designate. An appeal under this section is perfected only if accompanied by written documents including the following information:

      (1) A copy of the letter received from the Medical Services Division advising of that division's decision on the request for reconsideration.

      (2) A statement of each disputed item and the reason or basis for the dispute.

(3) A computation and the dollar amount which reflects the appealing party's claim as to the correct computation and dollar amount for each disputed item.

(4) The authority in statute or rule upon which the appealing party relies for each disputed item.

(5) The name, address, and telephone number of the person upon whom all notices will be served regarding the appeal.

b. Upon the request of the provider, the department shall refer the appeal to the attorney general for the appointment of a hearing officer, knowledgeable in rate setting matters, who is not an employee of the department and who has not been involved in the decision which the provider has appealed.

Section 32 - Classifications

1. A facility shall complete a resident assessment for any resident occupying a licensed facility bed, except a respite care, hospice inpatient respite care, or hospice general inpatient care resident.

2. A resident must be classified in one of thirty-four classifications based on the resident assessment. If a resident assessment is not performed in accordance with subsection 3, except for a respite care, hospice inpatient respite care or hospice general inpatient care resident, the resident must be included in group BC1, not classified, until the next required resident assessment is performed in accordance with subsection 3. For purposes of determining standardized resident days, any resident day classified as group BC1 must be assigned the relative weight of one. A resident, except for a respite care, hospice inpatient respite care or hospice general inpatient care resident, who has not been classified, must be billed at the group BC1 established rate. The case-mix weight for establishing the rate for group BC1 is .62. Days for a respite care, hospice inpatient respite care, or hospice general inpatient care resident who is not classified must be given a weight of one when determining standardized resident days.

3. Resident assessments must be completed as follows:

   a. The facility shall assess the resident within the first fourteen days after any admission or return from an acute hospital stay. The day of admission or return is counted as day one.

   b. The facility shall assess the resident quarterly after any admission or return from an acute hospital stay. The quarterly assessment period ends on the day of the third subsequent month corresponding to the day of admission or return from an acute hospital stay, except if that month does not have a corresponding date, the quarterly assessment period ends on the first day of the next month. The assessment reference period begins seven days prior to the ending date of a quarterly assessment period. The assessment reference date (A3a) on the MDS must be within the assessment reference period.

4. The resident classification is based on resident characteristics and health status recorded on the resident assessment instrument, including the ability to perform activities of daily living, diagnoses, and treatment received. The classification is determined using an index maximizing method. Index maximizing identifies all groups for which a resident qualifies and the resident is then classified in group with the highest case mix index. The resident is first classified in one or more of seven major categories. The resident is then classified into subdivisions of each major category based on the resident's activities of daily living score and whether nursing rehabilitation services are needed or the resident has signs of depression. A resident meeting the criteria for more than one classification shall be classified in the group with the highest case-mix weight.

5. For purposes of this section:

a. A resident's activities of daily living score used in determining the resident's classification is based on the amount of assistance, as described in the resident assessment instrument, the resident needs to complete the activities of bed mobility, transferring, toileting, and eating;

b. A resident has a need for nursing rehabilitation services if the resident receives two or more of the following for at least fifteen minutes per day for at least six of the seven days preceding the assessment:

(1) Passive or active range of motion;
(2) Amputation or prothesis care;
(3) Splint or brace assistance;
(4) Dressing or grooming training;
(5) Eating or swallowing training;
(6) Bed mobility or walking training;
(7) Transfer training;
(8) Communication training; or
(9) Any scheduled toileting or bladder retraining program; and

c. A resident has signs of depression if the resident exhibits at least three of the following:

(1) Negative statements;
(2) Repetitive questions;
(3) Repetitive verbalization;
(4) Persistent anger with self and others;
(5) Self deprecation;
(6) Expressions of unrealistic fears;
(7) Recurrent statements that something terrible is to happen;
(8) Repetitive health complaints;
(9) Repetitive anxious complaints or concerns of nonhealth-related issues;
(10) Unpleasant mood in morning;
(11) Insomnia or changes in usual sleep patterns;
(12) Sad, pained, or worried facial expression
(13) Crying or tearfulness;
(14) Repetitive physical movements;
(15) Withdrawal from activities of interest; or
(16) Reduced social interaction.

6. The major categories in hierarchial order are:

a. Rehabilitation category. To qualify for the rehabilitation category, a resident must receive rehabilitation therapy and qualify for the extensive services category, special care category, or clinically complex category if the rehabilitation therapy is not provided. A resident who qualifies for the rehabilitation category is assigned a subcategory based on the resident's activities of daily living score.